114.1 CMR 41.00: Rates of Payment for Services Provided to Industrial Accident Patients by Hospitals

Section

41.01: General Provisions

(1) Scope, Purpose and Effective Date.

(a) 114.1 CMR 41.00 implements the provisions of M.G.L. 118G regarding acute care and non-acute care hospitals.(b) The purpose of 114.1 CMR 41.00 is to determine the methods and procedures for establishing rates of payment for care and services rendered to industrial accident patients by hospitals under M.G.L.c.152.

(c) Except as provided in 114.1 CMR 41.01(1)(b), no insurer shall be liable for health care services in excess of the rate established for that service by the Division, regardless of the setting in which the service is administered.

(d) No employee shall be liable for health care services adjudged compensable under MGL c. 152.(e) 114.1 CMR 41.00 shall become effective January 1, 2004.

(2) Reimbursement as Full Payment. Each hospital that accepts payment for hospital care and services provided to industrial accident patients shall accept reimbursement at rates established by the Divisionas full payment and discharge of all obligations of industrial accident patients for care and services purchased under 114.1 CMR 41.00. There shall be no duplication or supplementation of payment.

(3) Rate in Effect. The rate in effect on the day a service is provided is the rate in effect for that service.

(4) Hospital Billing Requirements. Beginning January 1, 1994, hospital bills shall conform to Department of Industrial Accidents billing requirements set forth in 452 CMR 7.02 and any amendments or circular letters thereto.

(5) Hospital Categories. The Massachusetts Division of Health Care Finance and Policy recognizes two categories of hospitals subject to the provisions of rate determination within 114.1 CMR 41.00. These hospitals are categorized as:

(a) Acute care hospitals
(b) Non-Acute care hospitals

(6) Administrative Adjustments

(a) If, at its own initiative, the Division concludes that an error has been made in a determination made pursuant to 114.1 CMR 41.00, it may correct such error.
(b) A hospital may apply for an administrative adjustment if the hospital believes an arithmetic, mechanical, or clerical error exists in a determination made pursuant to 114.1 CMR 41.00. The Division will not entertain a request for an administrative adjustment if the hospital is seeking to reverse a substantive determination pursuant to 114.1 CMR 41.00. The request for an administrative adjustment must be received by the Division within 20 business days of the date of notification of the Division's determination. The request must be in writing and contain a precise explanation of the perceived error as well as any documentation to support the request.

(7) Administrative Information Bulletins

The Division may issue administrative information bulletins to clarify its policies on and understanding of substantive provisions of 114.1 CMR 41.00.

41.02: Definitions

As used in 114.1 CMR 41.00, unless the context requires otherwise, terms shall have the meanings ascribed in 114.1 CMR 41.02:

Acute Hospital. A hospital licensed under MGL c. 111, § 51, which contains a majority of medical-surgical, pediatric, obstetric, and maternity beds, as defined by the Department of Public Health, and the teaching hospital of the University of Massachusetts Medical School.

At Invoice Cost (A.I.). The price paid by the provider net of any manufacturer discounts received. Documentation of A.I. cost must be supplied to purchaser for payment upon request.

Base Year. For acute care hospitals that were licensed and operating during hospital fiscal year (HFY) 1996, the base year is HFY 1996. For merged and/or consolidated hospitals the base year shall be the first full year when merged data become available. For new hospitals, which were not licensed and/or operated as a hospital in HFY 1996, or did not have a base year previously established, the base year for all costs shall be the first full year of costs. If the Division determines that the data source is inadequate or not representative of the hospital's ongoing costs, the Division may consider alternative data sources to determine Base Year costs. Criteria for such review will include but shall not be limited to peer group analysis of costs incurred and the determination of approved rates for comparable facilities. For non-acute care hospitals, the base year shall mean the last HFY that adequate DHCFP-403 data are available.

Charge. A hospital's uniform price for each specific service within a revenue center.

Department of Public Health. The Department of Public Health as established under MGL c. 17, §1.

DHCFP-403. The DHCFP-403, the Hospital Statement of Costs, Revenues and Statistics, which is the successor form to the RSC-403. The DHCFP-403 is filed annually with the Division within 120 days of the close of the hospital's fiscal year.

Division. The Division of Health Care Finance and Policy of the Executive Office of Health and Human Services is established under M.G.L. c.118G.

Governmental Unit. The Commonwealth, any department, agency, board or commission of the Commonwealth, and any political subdivision of the Commonwealth.

Gross Patient Service Revenue. The total dollar amount of a hospital's charges for services rendered in a fiscal year.

Hospital Uniform Assessment Percentage. Massachusetts acute hospitals' liability to the uncompensated care pool, expressed as a percentage of statewide acute hospital private sector revenue. An individual acute hospital's gross liability to the uncompensated care pool equals the hospital uniform assessment percentage multiplied by that hospital's private sector revenue.

Industrial Accident Patient. A person who receives hospital services for which an employer or insurer is in whole or part liable under MGL c. 152, Workers' Compensation Act.

New Hospital. A hospital which was not licensed and/or operated as a hospital in HFY 1996, or which did not report a full year of actual costs in HFY 1996. For non-acute hospitals, a new hospital is one that has not yet established a base year.

Non-Acute Hospital. A hospital which is defined and licensed under MGL c. 111, §51, with less than a majority of medical-surgical, pediatric, maternity and obstetric beds, or any psychiatric facility licensed under MGL c. 19, §19, or any public health care facility.

Observation Services. Outpatient services consisting of the use of a bed and intermittent monitoring by professional licensed staff that are reasonable and necessary to evaluate an outpatient's condition in order to determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided under the order of a physician. Observation services may not exceed 48 hours.

Payment on Account Factor (PAF). The percentage applied to charges to calculate a discounted reimbursement level for eligible services rendered to industrial accident patients which is approved by the Division, as determined in accordance with 114.1 CMR 41.03.

Private Sector GPSR. Total hospital charges attributable to all patients less managed care and non-managed care gross patient service revenue attributable to Titles XVIII and XIX, other publicly aided patients, free care, and bad debt.

Public Health Care Facility. A facility operated by the Department of Public Health, the Department of Mental Health, a County of the Commonwealth, , skilled nursing, or mental retardation care and services and which may provide outpatient medical, mental health, or mental retardation care and services.

Publicly Aided Individual. A person for whose medical or other services a governmental unit is in whole or in part liable under a statutory public program.

Rate Year. For all hospitals, the year beginning October 1.

Rehabilitation Services. Comprehensive services deemed appropriate to the needs of a disabled person, in a program designed to achieve objectives of

improved health and welfare with the realization of optimal physical, social and vocational potential.

Restorative Services. Physical Therapy (PT), Occupational Therapy (OT) or Speech Therapy (ST) services for the purpose of maximum reduction of physical and/or speech disability and restoration of optimal functional levels.

Speech/Language Pathology Services. The evaluation and treatment of communicative disorders with regard to the functions of articulation (including aphasia and dysarthria, language, voice and fluency.)

Update Year. The most recent year that casemix data are available for purposes of revising the rate year PAF for acute care hospitals.

41.03 Hospital Inpatient Rates

(1) Acute Hospitals

(a) Determination of Industrial Accident Inpatient Rates of Payment for Massachusetts Acute Hospitals. Payment for any eligible inpatient service, and outpatient or observation stay as defined in 114.1 CMR 4.04(2) provided to an industrial accident patient by an acute hospital shall be equal to the product of the industrial accident PAF and the published charge for the service. The Division will determine the hospital-specific industrial accident Rate Year Payment on Account Factor (PAF) calculated as follows:

1. The rate year PAF equals the lower of 1.0 or the hospital's base year Private Sector Gross Patient Service Revenue (PSGPSR) minus its base year private sector contractual adjustments divided by its base year Private Sector Gross Patient Service Revenue (PSGPSR). Private sector revenues and contractual adjustments used in this calculation will be those reported on the DHCFP-403 Schedule V-A cost report from Industrial Accident, Managed Care and Non-Managed Care payer groups.

$$\text{Rate Year PAF} = \text{the lower of } 1.0 \text{ or } \frac{(\text{Base Year PSGPSR} - \text{Base Year Private Sector Contractual Adjustments})}{\text{Base Year PSGPSR}}$$

2. The percentage equal to the lower of 1.00 or the total hospital's total base year Gross Patient Service Revenue (GPSR) minus its base year total hospital contractual adjustments divided by its base year total hospital GPSR.

3. For any hospital resulting from a merger, consolidation, or other such arrangement, a single updated PAF will be calculated when merged data and

charges become available. Merged or consolidated hospitals shall utilize the PAF approved for the specific site of service until a single updated PAF is calculated and approved by the Division. In the event that there is no individual PAF approved for the site of service, the median PAF multiplied by charges shall be payment for all eligible inpatient and emergency department services rendered.

4. For a new hospital or hospital for which an approved PAF is not yet determined, the acute hospital median PAF multiplied by charges shall be payment for any eligible inpatient service, and outpatient or overnight observation stay rendered as defined in 114.1 CMR 40.04(2).

(b) Annual Update of Industrial Accident Inpatient Rates of Payment. Industrial Accident rates of payment may increase by no more than the rate of inflation, as measured by the Centers for Medicare & Medicaid Services (CMS) Hospital Market Basket Prospective Payment System (PPS) Index.

1. The Division will conduct the following analysis to determine whether it must update a hospital's PAF. The Division will determine the actual increase in private sector charges by dividing the average charge per case-mix adjusted discharge (CMAD) for the most recent year for which case-mix data are available by the average charge per case-mix adjusted discharge in the base year. For simplicity, the Division will refer to the most recent year for which case-mix data are available as the "update year". If the result of this division is greater than one plus the CMS Hospital Market Basket Index for the period from the base year to the update year then the Division will update the hospital's PAF. If the result of this division is less than or equal to one plus the CMS Market Basket Index for the period from the base year to the update year, no further action will be taken and the hospital shall maintain its current PAF during the new rate year.

2. The Division will conduct the following analysis. If the percentage increase as determined by 114.1 CMR 41.03(1)(b)1. is greater than one plus the CMS Hospital Market Basket Index, the updated PAF will be determined as follows. The Division will multiply the base year PAF by one plus the CMS Hospital Market Basket Index and divide by the actual percentage increase as determined pursuant to 114.1 CMR 41.03(1)(b)1. This calculation is expressed algebraically by the following formula:

((Base Year PAF * (1+CMS Hospital Market Basket Index)) / (Update Year Average Charge per CMAD)) / Base Year Average Charge per CMAD

3. The PAF ratio established in 114.1 CMR 41.03(1) shall not exceed 1.00.

(c) Determination of Industrial Accident Inpatient Rates of Payment for Out of State Acute Hospitals.

1. On an annual basis, the Division shall establish a PAF for out of state acute hospitals that provide inpatient services or outpatient care in accordance with 114.1 CMR 41.01(3) to industrial accident patients as follows. The Division shall group the PAFs for all acute care hospitals in the Commonwealth as determined in 114.1 CMR 41.03(1), and calculate the median PAF. The median acute hospital PAF shall be established as the PAF for reimbursement of out of state acute hospitals.
2. The industrial accident inpatient rate of payment for out of state acute hospitals will be determined by multiplying the gross charges for services rendered by the PAF for out of state acute hospitals calculated pursuant to 114.1 CMR 41.03(1)(c)1.

(d) Timing of Rate Determination.

1. The Division will update the inpatient PAF annually on a prospective basis.

2. Industrial accident rates of payment established pursuant to 114.1 CMR 41.03 shall remain in effect until an update review is conducted and an adjusted PAF is calculated in accordance with 114.1 CMR 41.03(1)(b).

(e). Data Sources for the Calculation of the PAF and Yearly Update.

1. The Division shall use the data sources cited in 114.1 CMR 41.03(1)(b) in its calculation of the industrial accident rates of payment unless the specified data source is unavailable or inaccurate. In either of these two cases, the Division shall use the most comparable available data source. In the event that the Division uses a comparable data source, the Division will consider a hospital's request to submit additional data.
2. The Division shall use the base year DHCFP-403 cost report to calculate the rate year PAF.
3. For purposes of calculating the updated PAF, the Division shall use the most recent four quarters of the merged billing and discharge tapes (case-mix data) submitted pursuant to 114.1 CMR 17.00. The Division shall utilize the New York All Patient-Diagnosis Related Groups, Version 15, and the New York weights, for the appropriate year when calculating the updated PAF.

(2) Non-Acute Hospitals

(a). Determination of Industrial Accident Inpatient Rates of Payment for Massachusetts Non-Acute Hospitals. Payment for any eligible inpatient service, and outpatient or overnight observation stay as defined in 114.1 CMR 40.04(2) provided to an industrial accident patient by a non-acute hospital shall be equal to the product of the industrial accident PAF and the published charge for the service. The Division will determine the hospital-specific industrial accident Rate Year Payment on Account Factor (PAF) calculated as follows:

1. The rate year PAF equals the lower of 1.0 or the hospital's base year Private Sector Gross Patient Service Revenue (PSGPSR) minus its base year private sector contractual adjustments divided by its base year Private Sector Gross Patient Service Revenue (PSGPSR). Private sector revenues and contractual adjustments used in this calculation will be those reported on the DHCFP-403 Schedule V cost report from Blue Cross, Industrial Accident, Commercial and HMO payer groups. If the specified data source is unavailable or inaccurate, the Division shall use the most comparable data source. In the event that the Division uses a comparable data source, the Division will consider a hospital's request to submit additional data.

Rate Year PAF = the lower of 1.0 or

$$\frac{\text{Base Year PSGPSR - Base Year Private Sector Contractual Adjustments}}{\text{Base Year PSGPSR}}$$

2. The percentage equal to the lower of 1.00 or the total hospital's total base year Gross Patient Service Revenue (GPSR) minus its base year total hospital contractual adjustments divided by its total hospital GPSR.

3. For any hospital resulting from a merger, consolidation, or other such arrangement, a single updated PAF will be calculated when merged data and charges become available. Merged or consolidated hospitals shall utilize the PAF approved for the specific site of service until a single updated PAF is calculated and approved by the Division. In the event that there is no individual PAF approved for the site of service, the median PAF multiplied by charges shall be payment for all eligible inpatient and emergency department services rendered.

4. For a new hospital or hospital for which an approved PAF is not yet determined, the non-acute hospital median PAF multiplied by charges shall be payment for any eligible inpatient service, and outpatient or overnight observation stay rendered as defined in 114.1 CMR 40.04(2).

(b) Determination of Industrial Accident Inpatient Rates of Payment for Out of State Non-Acute Hospitals.

1. On an annual basis, the Division shall establish a PAF for out of state non-acute hospitals that provide care and services to industrial accident patients as follows. The Division shall group the approved PAFs for those non-acute care hospitals in the Commonwealth as determined in 114.1 CMR 41.03(2)(a), and calculate the median PAF. The median non-acute hospital PAF shall be established as the PAF for reimbursement of out of state non-acute hospitals.
2. The industrial accident inpatient rate of payment for out of state non-acute hospitals will be determined by multiplying the gross charges for services rendered by the PAF for out of state non-acute hospitals calculated pursuant to 114.1 CMR 41.03(2)(b)1.

(c) Timing of Rate Determination.

1. The Division will update the non-acute inpatient PAF on a prospective basis annually in accordance with 114.1 CMR 41.03 (2)(a).
2. Industrial accident rates of payment established pursuant to 114.1 CMR 41.03 shall remain in effect until an update review is conducted and an adjusted PAF is calculated in accordance with 114.1 CMR 41.03(2)(a).

41.04 Hospital Outpatient Rates

(1) Services Available in Hospitals and Ambulatory Care Settings

(a) Services Other than Rehabilitation Clinic Services and Restorative Services. Industrial accident insurers shall compensate hospitals for outpatient services, unless otherwise specified below in 114.1 CMR 41.04(1)(b)2 and 41.04(2) and (3)(a) and (b), at rates established for comparable services in accordance with 114.3 CMR 40.00, Rates for Services Under M.G.L.c.152, Worker's Compensation Act.

(b) Rehabilitation Clinic Services and Restorative Services

1. Fees for Sites of Service After July 1, 1993. Payment for rehabilitation clinic or restorative services which the hospital acquires or begins to

provide in a new program or new location *after* July 1, 1993, shall be equal to the rates specified in 114.3 CMR 40.00.

2. Fees for Sites of Service Before July 1, 1993. The rates for individual outpatient physical, occupational, and speech therapy services which a hospital acquired or began providing in a new program or new location *before* July 1, 1993 are listed below. A list of these sites of service is available on the Division's web site at www.mass.gov/dhcfp.

   a. Fees for Physical Therapy and Occupational Therapy in OPD Clinics and Satellites Owned and Operated by a Hospital Prior to July 1, 1993. These rates apply to all hospitals except those listed in 114.1 CMR 41.04(1)(b)2.c.

CODE	FEE	DESCRIPTION
97001	80.27	Physical therapy evaluation
97002	43.46	Physical therapy re-evaluation (per 30 minutes)
97003	85.92	Occupational therapy evaluation
97004	53.45	Occupational therapy re-evaluation (per 30 minutes)
97010	4.80	Application of a modality to one or more areas; hot or cold packs
97012	16.10	Application of a modality to one or more areas; traction, mechanical
G0283	14.24	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care
97016	15.55	Application of a modality to one or more areas; vasopneumatic devices
97018	7.41	Application of a modality to one or more areas; paraffin bath
97020	5.24	Application of a modality to one or more areas; microwave
97022	16.46	Application of a modality to one or more areas; whirlpool
97024	5.24	Application of a modality to one or more areas; diathermy
97026	5.24	Application of a modality to one or more areas; infrared
97028	6.45	Application of a modality to one or more areas; ultraviolet
97032	17.83	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97033	15.92	Application of a modality to one or more areas; iontophoresis, each 15 minutes
97034	15.41	Application of a modality to one or more areas; contrast baths, each 15 minutes
97035	13.24	Application of a modality to one or more areas; ultrasound, each 15 minutes
97036	25.51	Application of a modality to one or more areas; Hubbard tank, each 15 minutes
97039	12.85	Unlisted modality (specify type and time if constant

CODE	FEE	DESCRIPTION
		attendance)
97110	30.55	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	31.55	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination,kinesthetic sense, posture, and proprioception
97113	32.77	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	27.00	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)
97124	24.32	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking,compression, percussion)
97139	17.58	Therapeutic procedure, one or more areas, each 15 minutes; unlisted therapeutic procedure (specify)
97140	29.04	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97150	20.52	Therapeutic procedure(s), group (2 or more individuals)
97504	30.98	Orthotics fitting and training, upper and/or lower extremities, each 15 minutes
97520	30.25	Prosthetic training, upper and/or lower extremities, each 15 minutes
97530	31.16	Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functionalperformance), each 15 minutes
97532	26.08	Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes
97533	27.82	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes
97535	33.72	Self care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures,and instructions in use of assistive technology devices/adaptive equipment) direct one on one contact by provider, each 15 minutes
97537	29.51	Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or workenvironment/modification analysis, work task analysis), direct one–on-one contact by provider, each 15 minutes
97542	30.38	Wheelchair management/propulsion training, each 15 minutes
97545	147.92	Work hardening/conditioning; initial 2 hours
97546	73.96	Work hardening/conditioning; each additional hour

CODE	FEE	DESCRIPTION
97703	15.91	Checkout for orthotic/prosthetic use, established patient, each 15 minutes
97750	33.55	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes
97799	I.C.	Unlisted physical medicine/rehabilitation service or procedure

b. Fees for Speech Therapy in OPD Clinics and Satellites Owned and Operated by a Hospital Prior to July 1, 1993. These rates apply to all hospitals except those listed in 114.1 CMR 41.04(1)(b)2.c.

CODE	FEE	DESCRIPTION
92506	105.42	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status
92507	88.56	Treatment of speech, language, voice, communication, and/ or auditory processing disorder (includes aural rehabilitation); individual
92508	73.38	Treatment of speech, language, voice, communication, and/ or auditory processing disorder (includes aural rehabilitation); group, two ormore individuals
92510	169.66	Aural rehabilitation following cochlear implant (includes evaluation of aural rehabilitation status and hearing, therapeutic services) with or without speech processor programming
92526	92.33	Treatment of swallowing dysfunction and/or oral function for feeding

c. Exceptions. To comply with the requirements of M.G.L.c.152 §13, the rates for the following hospitals shall equal the higher of the rates contained in 114.3 CMR 40.00 or the product of the fees listed in 114.1 CMR 41.04(1)(b)2.a. and 114.1 CMR 41.04(1)(b)2.b. and the hospital specific percentage listed below:

Hospital Name	Physical Therapy: Fee X %	Occupational Therapy: Fee X %	Speech Therapy: Fee X %
Brockton Hospital	79%	100%	100%
Fairlawn Hospital	99%	99%	99%

Hospital Name	Physical Therapy: Fee X %	Occupational Therapy: Fee X %	Speech Therapy: Fee X %
Mass. Eye and Ear	100%	92%	100%
New England Rehabilitation Hospital	86%	86%	86%
North Shore Medical Center – Shaughnessy Kaplan Rehab	87%	91%	82%
Southwood Community Hospital	88%	100%	100%

3. Functional Capacity Assessments. To report a functional capacity assessment (or Key functional assessment) use CPT code 97750 that may be billed up to a maximum of nine (9) units.
4. Work Hardening and Work Conditioning. Work hardening and work conditioning are goal-oriented therapies designed to prepare injured workers for their return to work. Use CPT codes 97545 and 97456 to report these services.
5. Modalities. A charge may be assessed for supportive services (CPT codes 97010-97039) only in conjunction with a procedure performed during the course of the same visit. A maximum of three supportive services per visit is allowed. When determining the correct units allowed, round up to the nearest fifteen minute block of time (e.g. 1-15 minutes = 1 unit, and 16-30 minutes = 2 units).

(c) When an industrial accident insurer compensates Massachusetts acute care hospitals for outpatient services at rates pursuant to 114.1 CMR 41.04(1)(a) or (b), the insurer shall pay a separate and additional uncompensated care fee to reflect the costs such hospitals incur for their gross liability to the uncompensated care pool. The additional fee is the product of the final hospital uniform assessment percentage for the pool fiscal year prior to the hospital's rate year and the total charge for services paid pursuant to 114.1 CMR 41.04(1)(a) or (b). No additional fee shall be paid when payment is made to Massachusetts acute hospitals pursuant to 114.1 CMR 41.04(2), or when payment is made to Massachusetts non-acute hospitals or to out-of-state hospitals.

(2) Outpatient Services Available Only in Hospitals. Industrial accident insurers shall compensate hospitals for the following services by applying the hospital's PAF, as established in 114.1 CMR 41.03, to charges for

(a) Emergency Room Services. Emergency Room (ER) Services occurring within three days of injury. All ER Services shall be paid using the PAF, except for those visits that are considered follow-up visits.

(b) Overnight Observation. An overnight observation stay for a workers' compensation patient following ambulatory day surgery.

(c) Ambulatory Surgery Expense. All surgical expenses for procedures performed in an outpatient surgical department, not on the Medicare-approved ASC list, shall be paid at the PAF. Items and/or expense not covered under routine surgical medical supplies and service expense under 114.3 CMR 40.00 shall be paid for using the PAF. Items included in implanted durable medical equipment (DME), implanted prosthetic devices, replacement parts (external or internal), accessories and supplies for the implanted DME shall be paid at invoice (A.I.) cost net of any manufacturer discounts received by the provider.

(d) Unlisted or Individual Consideration (I.C.) Services. Unlisted or Individual Consideration (I.C.) rates not addressed in 114.1 CMR 41.04 or 114.3 CMR 40.00.

(3) Out of State Outpatient Services

(a) Industrial accident insurers shall compensate out of state hospitals for outpatient services by applying the out of state PAF, as established in 114.1 CMR 41.03, to charges for outpatient services listed in 114.1 CMR 41.04(3).

(b) Industrial accident insurers shall compensate out of state hospitals for individual physical, occupational, and speech therapy using fees listed in 114.1 CMR 41.04(1)(b)2.

(c) Industrial accident insurers shall compensate out of state hospitals for all other outpatient services as provided in 114.1 CMR 41.04(1)(a).

41.05: Appeal

A hospital which is aggrieved by an action or failure to act under 114.1 CMR 41.00 may file an appeal within 30 days with the Division of Administrative Law Appeals, pursuant to the requirements of MGL 118G; MGL c. 7, § 4H. The pendency of an appeal does not limit the Division's right to undertake administrative review of charges under 114.1 CMR 41.00.

41.06: Severability

The provisions of 114.1 CMR 41.00 are severable. If any provision of 114.1 CMR 41.00 or the application of such provisions to any hospital, person, or circumstances should be held invalid or unconstitutional, such determination shall not be construed to affect the validity or constitutionality of any other provision of 114.1 CMR 41.00 or the application of such provisions to other hospitals, persons or circumstances.

Regulatory Authority

114.1 CMR 41.00: MGL c. 152, § 13 and MGL c. 118G.